MEDICAID APPLICATION - WOMEN'S WAY

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 416 (Rev. 04-2003)

PLEASE PRINT AND COMPLETE FORM IN DETAIL. PLEASE BE SPECIFIC AND FILL IN ALL APPROPRIATE BLANKS AS ACCURATELY AS YOU CAN. IF YOU DO NOT UNDERSTAND A QUESTION, THE WOMEN'S WAY CASE MANAGERS ARE AVAILABLE TO ASSIST YOU.

Name of Applicant: (Last, First, Middle Initial)	Social Security Number:			Date of Birth:
Address Where You Live:	City:	State:	Zip Code:	Home Telephone Number:
Mailing Address: (If Different)	City:	State:	Zip Code:	Work Telephone Number:

Race:
☐ White ☐ American Indian/Alaska Native ☐ Black ☐ Asian ☐ Native Hawaiian/Pacific Island ☐ Hispanic

Are You a US Citizen?
☐ Yes ☐ No If No, Documentation of Alien Status Must be Provided.

Please Indicate What Type(s) of Other Health Insurance Coverage, if Any, You Have: ☐ Drug ☐ Dental ☐ Vision
☐ Medical ☐ Hospital ☐ Cancer ☐ Other _____ ☐ None

Policy Number:	Company Name:		
Address:	City:	State:	Zip Code:

YOUR RIGHTS AND RESPONSIBILITIES

1. I authorize any person having custody or knowledge of information relating to me to disclose any requested information, including confidential information, to any authorized agent of the North Dakota Department of Human Services. This authorization will remain valid until revoked in writing or until determined to be no longer eligible for assistance. A copy of this authorization is as valid as the original.

   I understand by signing this application, I authorize the Department of Human Services and the North Dakota Department of Health to disclose to each other information regarding any services or benefits I receive under the Breast and Cervical Cancer Prevention and Treatment plan.

2. I understand that any information I have given may be reviewed and verified by the Department of Human Services and the North Dakota Department of Health staff. Also, I understand that I must cooperate fully with the Department of Human Services and the North Dakota Department of Health and Centers for Medicare & Medicaid Services workers if my case is reviewed.

3. I certify that all the information I have provided on this form is true and correct to the best of my knowledge. I certify that all statements on this form have been read by me or read to me and I understand all the questions.

4. I understand if I give incorrect or false information, or if I fail to report changes, I may be required to repay any benefits I receive. I understand that state and federal law provide for fine, imprisionment, or both for any person who withholds or gives false information to obtain assistance to which she is not entitled.

5. I understand that this application will be considered without regard to race, color, gender, age, disability, religion, political belief, or national origin.

6. I understand that the disclosure of my social security number is required pursuant to 42 CFR 435.910 and is requested for identification and for the purpose of determining eligibility and the amount of Medicaid payments. Failure to disclose this information will affect participation in this program.

7. I understand that by accepting Medicaid I have assigned any and all money that is received from any third party, including an insurance company, for repayment of medical and/or hospital bills for which the Medicaid program has made or will make payment.

Signature of Applicant:	Date: